|  |  |
| --- | --- |
| Family Name |  |

|  |  |
| --- | --- |
| EHA ID No. |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Children subject to the Early Help Assessment who need to be closed** | | | |
| Name |  | DOB |  |
| Name |  | DOB |  |
| Name |  | DOB |  |
| Name |  | DOB |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Children subject to the Early Help Assessment who need to remain open** | | | |
| Name |  | DOB |  |
| Name |  | DOB |  |
| Name |  | DOB |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Lead Professional Name |  | Role |  |
| Contact Telephone Number |  | Organisation |  |
| Date |  |

|  |  |
| --- | --- |
| **Presenting Family Issues (tick all applicable)** | |
| **☐** Crime / ASB  **☐** Education  **☐** Children needing help | **☐** Domestic Violence and Abuse  **☐** Employment/finances  **☐** Health (including mental health)  **☐** Other reasons |

|  |
| --- |
| **Type of closure** |
| **☐** EHA to close all family members  **☐** EHA to close some family members but continue with others (please ensure named above) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Reason for closure** | | | | |
| **☐** Outcomes achieved  **☐** Moved out of County  (Consent to share with new area? Yes/No)  **☐** Referral accepted by Child in Need/ Child Protection  **☐** Withdrawal of consent | **☐** Deceased  **☐** Young Person/Family no longer engaged with process  **☐** Other reason……… please state below | | | |
| **Outcomes Achieved (please ensure you complete this section)** | | | | |
| **Details to be completed with the family wherever possible** | | | | |
| **c)** How effective has the Early Help process been in meeting the child/young person/family needs? | | **☐ Fully effective**  **☐ Partially effective**  **☐ Not effective** | |
| **On a scale of 1 to 5 can you rate how successful you feel the Early Help Assessment has been?**  **Lead Professional**  1 2 3 4 5  Not successful  Very successful  **Parent/Carer**  1 2 3 4 5  Not successful  Very successful  **Young person**  1 2 3 4 5  Not successful Very successful | | | | |
| **Any comments?…….** | | | | |
| **If you have contacted the Early Help First Contact Team or Early Help Locality for support?**  Early Help First Contact **Yes/No** Early Help Locality Team **Yea/No**  **Was this useful**  1 2 3 4 5 NA  Not at all Very useful | | | | |

|  |
| --- |
| Child/young person’s comments: |

|  |
| --- |
| Parents/Carers comments: |

|  |  |  |
| --- | --- | --- |
| Child/Young person’s name | Child/Young person’s signature | Date |
| Parents/Carers name | Parents/Carers signature | Date |
| Lead Professional name | Lead Professional signature | Date |